

<b>Case Number:</b>	CM14-0103287		
<b>Date Assigned:</b>	09/24/2014	<b>Date of Injury:</b>	09/06/2009
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	07/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/03/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in General Preventive Medicine and is licensed to practice in Indiana. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This employee is a 50 year old female with date of injury of 9/6/2009. A review of the medical records indicate that the patient is undergoing treatment for complex regional pain syndrome. Subjective complaints include neck pain and bilateral upper and lower extremity pain. Objective findings include swelling in wrists bilaterally, painful, decreased range of motion in the wrists, decreased range of motion in the neck and pain upon palpation of cervical paraveterbals. Treatment has included Ketamine infusions, spinal cord simulator, Gralise, Cymbalta, Duragesic, and Percocet. The utilization review dated 9/9/2014 partially-certified a Duragesic patch, and Percocet.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Duragesic 75 mcg/hr patch, #10 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system), Opioids Page(s): 44, 79. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioids, Specific drug list

**Decision rationale:** CA MTUS states and ODG agrees: "Not recommended as a first-line therapy. Duragesic is the trade name of a fentanyl transdermal therapeutic system, which releases fentanyl, a potent opioid, slowly through the skin . . . The FDA-approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means." ODG does not recommend the use of opioids "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does include pain assessments and includes current, least, and average. There is no current urine drug screen in the medical notes. With the multiple pain medications, there is serious risk of opioid dependence. As such, the request for Duragesic patch 75mcg #10 with 3 refills (fentanyl transdermal system) CII patch is not medically necessary.

**Percocet 10/325 mg, #120 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids

**Decision rationale:** Percocet (oxycodone with acetaminophen) is a short-acting opioid. Chronic pain guidelines and ODG do not recommend opioid "except for short use for severe cases, not to exceed 2 weeks" and "Routine long-term opioid therapy is not recommended, and ODG recommends consideration of a one-month limit on opioids for new chronic non-malignant pain patients in most cases, as there is little research to support use. The research available does not support overall general effectiveness and indicates numerous adverse effects with long-term use. The latter includes the risk of ongoing psychological dependence with difficulty weaning." Medical documents indicate that the patient has been on Percocet for several months, in excess of the recommended 2-week limit. Additionally, indications for when opioids should be discontinued include "If there is no overall improvement in function, unless there are extenuating circumstances". There is lack of documentation of 'overall improvement in function', which are indications of when an opioid should be discontinued. As such, the request for PERCOCET 10/325MG #120 is not medically necessary.